MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

ANSWER TO CLAIM FOR COMPENSATION

P.O. BOX 58
JEFFERSON CITY
MISSOURI 65102-0058

Injury Number	
DO NOT FILL IN	
Rec. Ack. Form >	
County >	
Place of Hearing >	
Checked By >	

NOTE: To be sent to the Division at Jefferson City, Missouri, within thirty (30) days of receipt of copy of claim for compensation. Send one copy for the Division, one copy for each claimant, and one copy for each claimant's attorney.

STATE FACTS AND NOT CONCLUSIONS

1. Claimant		Social Security No.	
Address		State	Zip Code
2. Name of Employer	Address	State	Zip Code
3. Name of Insurer	Address	State	Zip Code
4. Injured Employee			
5. Date of Accident	Place (City)	State	Zip Code

7. **All of the statements in the Claim for Compensation are admitted except the following:**
Here should be separately set forth the question number of each disputed statement in the Claim for Compensation, the reason why disputed, and the facts in regard thereto. Also any other facts tending to defeat the claim.

19. Dated	
20. Employer's Signature	22. Insurer's Signature
21. By	23. By

24. Attorney Signature	25. Bar Number	26. Telephone Number	27. Fax Number
28. Attorney Address	29. City	30. State	31. Zip Code

If additional space is needed, use reverse side.